

Phenomenology of Obsessive-Compulsive Neurosis

By R. S. STERN and J. P. COBB

SUMMARY Forty-five patients with obsessive-compulsive neurosis were given a specially devised structured interview with the aim of elucidating aspects of the phenomenology. Four main kinds of ritual were found to predominate: cleaning, avoiding, repeating and checking. A surprisingly large number of patients had little or no resistance to carrying out their rituals. The recognition of senselessness of a ritual was a more important criterion than that of resistance, but patients with predominantly repeating rituals did demonstrate resistance. It is proposed that a redefinition of obsessive-compulsive neurosis with less emphasis on resistance as a necessary condition may be appropriate.

Introduction

'In a would-be definite inquiry that I have been making into obsessional illness, I have been struck by the variety of problems and the difficulty of stating them' (Lewis, 1935). Despite this tentative note in the introduction to Lewis's classical study, the conclusions drawn from the unsystematic retrospective survey of case notes of 50 patients have not subsequently been challenged. Textbooks (Mayer-Gross, Slater and Roth, 1969; Beech, 1974) and research papers (Akhtar *et al.*, 1975) continue to reiterate Lewis's claim that there are two essential components of obsessional rumination and rituals, the first being compulsion and the second resistance, while the recognition that such obsessions are seen as senseless (Schneider, 1925) is considered to be of subsidiary importance.

Subdivision of the phenomena involved in obsessional neurosis has traditionally been made into form and content. Janet (1903) classified forms into ideas or images; impulses; phobias; thinking or ruminations. Filth, harm, sex or religion (Lewis, 1935); disgust (Strauss, 1948); aggression (Stengel, 1951); meticulousness and a sense of incompleteness (Janet, 1903) have all been emphasized as important contents of rumination. Though these subdivisions have

been given importance in the psychoanalytic literature (Fenichel, 1945) and by others who have speculated about the psychopathology of obsessional neurosis (Strauss, 1948), they have been of little pragmatic value to clinicians (Walker, 1973; Capstick and Seldrup, 1973; Akhtar *et al.*, 1975). Jaspers (1913-63) divided contents into indifferent (normal) and alien (abnormal), and classifications based on this have been developed recently (Capstick and Seldrup, 1973; Walker, 1973), but this work is highly subjective.

The development of effective behavioural treatment for obsessional neurosis (Marks *et al.*, 1975) has produced a need for a re-evaluation of the phenomenology of obsessive-compulsive neurosis, with emphasis on clinically significant behavioural aspects as well as cognitive processes.

Obsessional neurosis is a rare condition. Among psychiatric populations the incidence ranges from 0.1 per cent to 4.6 per cent (Black, 1974), while the prevalence in the general population has been estimated at 0.05 per cent (Rudin, 1953; Woodruff and Pitts, 1964). Participation in an MRC study of treatment of obsessional neurosis thus provided an unusual opportunity to assess a fairly large series over a short period of time and evaluate their phenomenology.

Method

Forty-five consecutive patients referred by other psychiatrists or by general practitioners for inclusion in a treatment trial were assessed by the authors. The assessment consisted of an hour-long interview during which a structured, assessor-rated questionnaire was administered. Each of the questionnaire items was rated on a 0-4 scale for severity. The degree of severity was related to the amount of disruption to everyday life or distress caused to the patient. Only patients given the diagnosis of primary obsessional neurosis were included in this study. The criteria for inclusion were:

- (1) Presence of repetitive ruminations or rituals with a compulsive quality, which were seen by the patients or their families as in some way disabling;
- (2) Absence of any clear evidence of Schneiderian first rank symptoms in the present or past history;
- (3) Symptoms present for at least 12 months;
- (4) Symptoms not part of a primary depressive illness;
- (5) Patients aged over 16;
- (6) Symptoms independent of organic neurological pathology.

Content (ideation)

In addition to the behavioural form, the underlying rumination was recorded. By asking the question 'Is there any reason underlying that?' repeatedly, it was sometimes possible to uncover a number of themes, one underlying the other, rather like peeling skins off an onion; e.g.

Why do you wash? '*Because I feel dirty and uncomfortable.*'

Is there any reason for feeling dirty? '*Yes, I'm afraid of picking up and passing on germs.*'

Why is that bad? '*I might make someone ill, especially one of my children.*'

Why you and not others? '*Well I'm basically a bad person, and I can't trust myself not to do damaging things.*'

Questionnaire

Behavioural form

In contrast to previous classifications, which have been based on *cognitive* form, clinical experience suggested that subdivision into *behavioural* forms might be more productive. Patients' symptoms were rated according to eight separate subdivisions, which are illustrated in the examples given below. Choice of subdivisions was based partially on previous published work and partially on clinical experience. For example, a series of principal component analyses and factor analyses of data obtained from the Leyton Obsessional Inventory (Cooper, 1970) isolated three clusters of factors, namely (1) cleanliness, (2) checking, (3) incompleteness. Rachman (1974) described a condition characterized by slowness, and many authors have commented on the phobic avoidance shown by obsessionals. The differentiation between repeating and checking was made because of the 'magical' quality which is associated with the former. Illustrative examples of each of the forms are:

(i) *Repeating (J.H.)*. Every time a certain thought came into her mind she had to repeat whatever she was doing five times or in sets of five. She would touch a coffee cup five times, sip five times, stir the spoon in multiples of five and so on. This patient's main problem was that she had to do things by *numbers*, regardless of the type of activity being carried out.

(ii) *Checking (D.D.)*. Whenever leaving a room he would have to check that everything was in order, windows closed, lights off, gas taps off, furniture and possessions in the correct place, until he was satisfied. This process could take several hours. Here the main difficulty was in going back to *check* actions performed: after leaving the house he would no sooner step into the street than he would have to return to check the windows, doors, lights, etc.

(iii) *Cleaning (J.B.)*. Whenever her hands touched anything that might even remotely be considered dirty, she would have to scrub her hands and arms for at least five minutes. In the course of a normal day she would wash her hands about forty times. The exact number of

washes did not matter, unlike example (i), but this patient's aim was to achieve a state of bodily *cleanliness* which would give her satisfaction.

(iv) *Avoiding* (K.W.). Avoiding behaviours were the type of ritual that approximated most closely to those characteristic of phobic disorders. This patient showed *avoidance* of any object related in any way to chocolate, or even anything coloured brown. Her inability to approach objects of this colour greatly limited her activities, as she went to extreme lengths to avoid contact with them. In addition, she avoided anything associated with her deceased mother, including other members of the family and places which her mother had frequented.

(v) *Slowing* (J.K.). Simple tasks, such as tying a shoelace or doing up a button might take up to ten minutes, in the course of which the patient appeared lost in thought. Not only were there long pauses between each component of a task, but movements themselves appeared as if in slow motion. It was the *slowness* of motor actions that characterized this kind of ritual: the patient appeared to be moving as in a cinematograph film running at reduced speed.

(vi) *Striving for completeness* (J.K.). This patient's main concern was in the area of doubt whether he had completed an activity correctly. Dressing took over one hour, because he spent much time over a single button 'trying to prove to himself that it was done up properly'. In contrast to example (v), this patient carried out actions speedily enough but was then plagued by the thought that the ritual might not have been carried through according to prescription, and so quite simple actions consumed a great deal of time.

(vii) *Being meticulous* (C.M.). The main problem was a concern that objects should be arranged in a special, meticulous way. Small sharp objects, such as pencils, had to be arranged so that the point was directed away from the patient. This patient was preventing himself from carrying on his activities as a student because so much time was spent in arranging pencils, pens, erasers, etc., on his desk in an idiosyncratic *meticulous* way.

(viii) *Other*. Some patients' main ritual could not be classified into any of the above categories. K.F.'s main symptom was that after looking at the colours orange or red she then had an overwhelming desire to look at another colour to 'neutralize the effect of the red'. She also felt compelled to take special small backward steps whenever she entered a room in which there was a fire or a heater.

(ix) *Mixed*. It is important to note that each behavioural form was not exclusive. Thus, patient S.B. avoided anything she considered 'dirty'. If she came in contact with dirt she had to wash her hands several times until she 'felt clean'. She also spent considerable time checking gas taps, locks and so on. Her scores on behavioural forms were: repetition (4), checking (3), cleaning (3), avoiding (3).

Questions concerning rituals

These were rated on five-point scales and concerned the following areas:

(a) Resistance to performing the ritual—a series of probing questions were asked to determine whether the patient struggled against an internal resistance, or conversely just gave in and carried out the ritual activity.

(b) This question aimed at the patient's feelings about how sensible (or not) it was to carry out the ritual.

(c) The patient was asked whether he could stop the ritual if someone in whom he had confidence would take responsibility for the consequences if he did not ritualize.

(d) This question asked whether rituals occurred in one place only (e.g. in the patient's home) or regardless of place.

(e) This question asked about whether rituals depended on the presence of others in general, or could occur when the patient was alone.

(f) The aim here was to measure the amount of reassurance from family or friends that ritual activity demanded.

(g) The amount of family distress directly related to the obsessional rituals was measured.

(h) This question concerned the presence of an underlying belief system which could be of a religious or superstitious nature.

The whole questionnaire yielded 15 variables which were subjected to statistical analysis.

Results

Of this sample of 45 patients there were 19 men and 26 women. The age range was 18-61 years with a mean age of 35 years.

Table I shows that four behaviours predominated in the sample: 'cleaning', 'avoiding', 'repeating' and 'checking'. The remaining

behaviours occurred infrequently, and so were excluded from further statistical analysis. The total exceeds 100 per cent, as several patients showed more than one type of ritual.

Forty-six per cent of the same said they had slight resistance or no resistance at all, whereas 30 per cent made a great effort to resist (Table IIa).

Sixty-five per cent rated 3 or 4 (maximal) on the absurdity of their rituals, despite the fact that they carried on with them (Table IIb). Reassurance from a significant other person did not reduce ritual activity for 49 per cent of the sample, and for 11 per cent the rituals largely occurred in only one place (Table IIc and IId). The presence of another person was irrelevant in controlling the ritual in 75 per cent (Table IIe). The impact of the family was variable, 47 per cent of the patients stating that family reassurance was moderate or great, but 71 per cent caused moderate to heavy family distress (Table IIg and IIg).

TABLE I
Behavioural types of ritual (moderate or severe expressed as %)

Cleaning ..	51	Completeness ..	11
Avoiding ..	51	Meticulous ..	9
Repeating ..	40	Slowing ..	4
Checking ..	38	Other ..	4

TABLE II
Results of assessor-rated questionnaire
(all figures expressed as percentages)

	0	1	2	3	4
	None present		Moderate		Maximal
(a) Resistance to carrying out rituals	15	31	22	2	30
	Completely sensible		Rather silly		Absurd
(b) How sensible did patient consider ritual?	9	13	13	7	58
	Greatly		Some		Not at all
(c) Did reassurance reduce ritual?	9	18	15	9	49
	At one place		Mainly one place		Anywhere
(d) Geographical location in which rituals occurred	7	4	20	13	55
	Occurs always alone		Company irrelevant		Occurs always in company
(e) Did presence of others affect ritual?	7	13	75	4	0
	Not at all		Moderately		Great deal
(f) Did family reassurance occur?	44	9	18	9	20
	None		Moderate		Heavy
(g) Amount of family distress from rituals	18	11	22	11	38

TABLE III
Results of factor analyses of 15 variable questionnaire, and of 5 selected variables

	Variable			Loading		Percentage of variance	
	No. of variables in the analysis			15	5	15	5
Factor 1	Repeating rituals	..	..	+·72	+·63	27	67
	High resistance	..	..	+·56	+·69		
Factor 2	Checking rituals	..	..	—·65	+·63	19	20
	Avoiding rituals	..	..	+·69	—·67		
Factor 3	Cleaning rituals	..	..	+·74		30	
	Distress to family	..	..	+·88			

Further analysis was carried out in order to examine whether any clusters of different variables occurred. A varimax rotated factor analysis of the 15 variables was used, and Table III shows the three factors that resulted.

Loadings less than 0·5 have been excluded from the table for the sake of clarity, and the three factors all yielded Eigen values greater than 1.

A second factor analysis was performed on five variables chosen to test the relationship of 'resistance' to the four main kinds of rituals. Two factors resulted which were the same as in the 15 variable analysis (factor 1 and factor 2).

Behavioural forms were not mutually exclusive. Only 8 patients had a single behavioural type of ritual; 14 had two types and 23 had a mixture of three or more. This is illustrated by case (ix).

Ideas patients associated with rituals (Table IV)

These data were difficult to quantify and liable to subjective error despite the fact that leading questions were avoided. Many patients gave the impression that their responses were influenced by previous contact with psychiatrists.

Underlying themes

The most common underlying theme was that of causing harm, either to self or to others (18). Six patients directly referred to feelings of guilt and four to feelings of insecurity or incompetence.

TABLE IV
Ideas patients associated with their rituals

	% of patients	
Fear of acquiring or passing on disease (dirt, excreta, bacteria, chemicals)	..	38
'Magical' warding-off danger	16
Habit only	11
Sexual related fears (fear of indirect impregnation, fear of transmitting VD, etc)		9
Having to do things properly or seeking reassurance	11
Fear of sharp objects	7
Other fears (chocolate, dogs)	4
Miscellaneous (thrift, warding-off depression		4

Discussion

This study of 45 obsessive-compulsive patients questions the standard textbook definition of the condition 'the essential nature of the obsessional or compulsive symptom lies in its appearance as a mental content, an idea, image, affect, impulse or movement, with a *subjective sense of compulsion overriding an internal resistance*' (Mayer-Gross, Slater and Roth, 1969). A revised definition is proposed: 'the obsessive compulsive neurosis consists of either ruminations (or ideas) which are psychic phenomena

recurring in spite of the patient regarding them as alien and absurd and/or voluntary motor actions which are reluctantly performed despite their being regarded as alien and absurd.' These actions are defined in this paper as rituals, and the study has demonstrated a preponderance of four main kinds of ritual: cleaning, avoiding, repeating and checking. Considerable overlap between these categories occurred, but the presence of a particular form may have an important influence on the phenomenology.

Lewis (1935) suggested that resistance is found in all patients with obsessive-compulsive neurosis; but, in keeping with Walker (1973), our study shows that resistance is not an essential component. On the face of it, Schneider's criterion of 'recognition of senselessness' appears to be more important than Lewis's criterion of resistance. In this study 78 per cent of patients rated their rituals as either 'rather silly' or 'absurd', whereas only 54 per cent showed moderate to maximum resistance. However, it must be borne in mind that this study concerned itself with the here and now. Had we asked 'Have you ever in the past resisted your rituals?' rather than 'How much do you resist your rituals at present?' the resistance score might have differed. The study could be criticized further on methodological grounds: the structured questionnaire is a new instrument as yet untested for inter-rater reliability, although the two authors conferred over cases that were found difficult to categorize. Replication of these results using the same instrument would serve to strengthen the findings.

The factor analyses suggest that certain rituals are resisted more than others. In both factor analyses the *repeating* component was the one that was resisted. In other words, a patient with obsessional hand-washing does not resist the handwashing *per se* but resists repeating this activity several times over; a patient who has to check a large number of items in the house, e.g. gas taps, doors, electrical appliances, does not resist these actions first time round but resists repeating them more than once. This part of the study has refined Lewis's original concept of resistance, as in our sample, where resistance occurred it was to *repetition* of

an activity. The practical importance of this finding may well relate to the new behavioural treatments where a patient is taught to perform an action once: e.g. a patient who has to wash his hands 39 times is allowed to wash once only in therapy. Here an external control is applied to prevent the patient giving way to the impulse to wash more than once. At the end of successful therapy we do not know whether the patient has an internal resistance to the rituals which keeps them in check, or whether this is now redundant. Long-term post-treatment follow-up studies are planned in which the original questionnaire will be administered to the same patients.

It is widely assumed that obsessional rituals continue regardless of the environment. Contrary to this, our study found that 31 per cent of patients performed their rituals either exclusively or predominantly in one place. The importance of this finding lies in the fact that the majority of these patients confined their rituals to home. If patients of this group are admitted to hospital, it is likely that no symptoms will be noted, and it may be thought that they have cleared up, though the rituals may gradually re-establish themselves, usually over the course of weeks. This should be considered in assessing the value of hospital-based treatments and in planning home treatment programmes, the value of which has been pointed out by Boersma *et al* (1976).

The mere presence of another person did not reduce rituals in most cases (Table II), in contrast to the situation in agoraphobia, but reassurance from a person in whom the patient had confidence helped to prevent the ritual in 42 per cent of the sample.

The second factor produced in each factor analysis was a negative association between checking and avoidance rituals. This makes clinical sense, in that avoiding a particular object or situation is incompatible with going back to check. In this sense 'checkers' and 'avoiders' are opposite. Rachman (1976) discusses the hypothetical relationship of 'cleaning' compulsions and 'checking' compulsions and argues in the first place that one would expect to find an affinity between phobias and compulsive cleaning, and secondly that there should

be less similarity between phobias and compulsive checking. On the other hand, checking can be regarded as phobic avoidance of uncertainty. Whatever the theoretical relationships, the clinical significance of this finding emphasizes the need to ask patients separately about checking, avoiding, washing and repeating activities.

There was an association of cleaning rituals with great distress caused to the family, as found by Akhtar *et al* (1975). It appears that the cleaning component of obsessional behaviour caused the greatest distress. The patient who commandeers the family bathroom for hours at a time to clean or bathe himself or who is preoccupied with house cleaning activities exemplifies the kinds of distress caused, and suggests reasons why the family must invariably become distressed: a 'checker' might carry out his rituals alone and the family could be unaware of this.

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R. S. Stern, M.D., M.R.C.Psych., *Senior Lecturer and Honorary Consultant Psychiatrist*,
J. P. Cobb, M.R.C.P., M.R.C.Psych., *Research Worker and Honorary Senior Registrar*,
Institute of Psychiatry, De Crespigny Park, London, SE5 8AF.

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